

New Jersey Office of the Attorney General Division of Consumer Affairs

Division of Consumer Affairs
Board of Pharmacy
124 Halsey Street, 6th Floor, P.O. Box 45013
Newark, New Jersey 07101
(973) 504-6450

Application for an Out-of-State Pharmacy Registration

□ New	\$175	\$175 □		пе	\$175	
			Previous name:			
☐ Change of Ownership	\$175		Change of Location \$ Date of Proposed Relocation:		\$175	
Date of proposed acquisition _	· · · · · · · · · · · · · · · · · · ·					
	equired fees must acc k payable to the "New Do Not Ser	Jersey S		harmacy."		
Applicant - Please print or type in th	ne information request	ed below.	Provide the PIC	's full name not his	/her initia	
Name of Pharmacy			Area Code and	Telephone Number		
Street Address			Area Code and Fax Number			
City			State	ZIP Code	ZIP Code	
Resident State Pharmacy Permit Number	Toll-Free Telephone Num Patient/Pharmacist Comm		Area Code and Telephone Number (if different)			
Print Name of Pharmacist-in-Charge (PIC)	PIC's License Number		PIC's Weekly Hours of Employment			
Please affix below a copy of your preso	ription label used to shi	p controll	ed and noncontrol	lled substances into	New Jerse	
		·			<u> </u>	

Ownership Type - check one: ☐ Corporation* ☐ Partnership ☐ Individual ☐ Other				
On a separate sheet of paper, please provide the following information for each owner/officer, including professional designation (e.g. Pres. John Jones, M.D.): Name and title Address (business and home) Phone number (business and home) Social Security number Date of birth				
* If the pharmacy is a corporation, please complete: Date of incorporation Name and address of the registered agent of the corporation:				
Is the corporation's stock: ☐ Publicly traded; or ☐ Privately held?				
Pharmacy Hours of Operation				
Monday A.M. toP.M. Friday A.M. toP.M. Tuesday A.M. toP.M. SaturdayA.M. toP.M. Wednesday A.M. toP.M. SundayA.M. toP.M. Thursday A.M. toP.M.				
Types of practice(s) in which the pharmacy is to engage: (Check all that apply)				
□ Mail Order Pharmacy □ Long-Term Care Pharmacy □ Hospital Pharmacy □ Sterile Compounding □ Retail Pharmacy □ Non-Sterile Compounding □ Nuclear Pharmacy □ Other, please indicate:				
Criminal/Disciplinary Action History – Pharmacist-in-Charge and/or Owner/Officer(s):				
 Has the pharmacist-in-charge or any owner/officer of the pharmacy been or currently is: The subject of any disciplinary action by any government agency; The subject of any legal or adverse action by any law enforcement agency or any local, state or federal court; Charged with the commission of any felony in any state or jurisdiction; Convicted of a felony in any state or jurisdiction? Please indicate: □ Yes □ No 				
If you answered "Yes," to any of the above, please attach a letter of explanation as well as a certified copy of the final disposition for each incident. If the charges were dismissed, please provide a letter from the appropriate authority confirming dismissal of the charges.				
Criminal/Disciplinary Action History – Pharmacy:				
Has this pharmacy ever been the subject of any disciplinary or other adverse action by any other licensing agency, or by any other government agency, or by any local, state, or federal law enforcement agency, or by any local, state or federal court:				
Please indicate: Yes No If you answered "Yes," to the above, please attach a letter of explanation as well as a certified copy of the final disposition for each incident. If the charges were dismissed, please provide a letter from the appropriate authority confirming dismissal of the charges.				

Affidavit: Affidavit A below, must be completed by the owner, partner or by the principal officer as designated above. If the person executing Affidavit "A" is not also the pharmacist-in-charge of the pharmacy, then the pharmacist-in-charge must complete Affidavit "B." Please note that each affidavit must be sworn to before a Notary Public or other authorized officer. I do solemnly swear and affirm that the foregoing statements on this form or those on any attachment(s) to this form are to the best of my knowledge true and correct. Affidavit "A" Affidavit "B" Print Name of Owner, Partner or Officer Signature of above Subscribed and sworn to before me this Subscribed and sworn to before me this Subscribed and sworn to before me this

day of _____ in the year ____

My commission expires _____

Print Notary's name:

Notary's signature:

Affix Seal Here:

day of _____ in the year ____

My commission expires _____

Print Notary's name:

Notary's signature:

Affix Seal Here:

Required documentation which must be enclosed with this application:

- A dated copy of the most recent inspection report resulting from an inspection of this pharmacy conducted by the regulatory or licensing agency in the state or jurisdiction in which this pharmacy is located.
- A certified letter of good standing from the licensing authority in the state or jurisdiction in which this pharmacy is licensed, permitted or registered.

Note: Unless this required documentation is supplied, the application cannot be processed.